Senate

General Assembly

File No. 165

February Session, 2004

Substitute Senate Bill No. 60

Senate, March 22, 2004

The Committee on Program Review and Investigations reported through SEN. CRISCO of the 17th Dist., Chairperson of the Committee on the part of the Senate, that the substitute bill ought to pass.

AN ACT CONCERNING MEDICAL MALPRACTICE.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-32 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

There is established within the Insurance Department the "Medical Malpractice Screening Panel" which shall consist of members whose names shall be supplied by **[**the Connecticut State Medical Society**]** professional societies or associations that represent health care providers in this state and the Connecticut Bar Association. This panel may be added to whenever the need arises by requesting further names from **[**either the Connecticut State Medical Society or the Connecticut Bar Association**]** any such society or association. Members of the panel shall serve without compensation. The Insurance Commissioner may designate **[**a member of his**]** an employee of the department to administer the operation of and maintain the records for

such screening panel.

Sec. 2. Section 38a-33 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) Unless all parties to a claim for medical malpractice agree to resolve such claim by a civil action, no civil action shall be filed with respect to such claim until the proposed complaint in such action is filed with the Insurance Commissioner and a hearing panel selected pursuant to subsection (c) of this section has made and recorded a finding as to liability or dismissed the claim pursuant to sections 38a-32 to 38a-36, inclusive, as amended by this act.

(b) The claimant shall personally deliver or cause to be delivered, or send, by registered or certified mail, return receipt requested, the proposed complaint to the Insurance Commissioner. Not later than ten days after receipt of such proposed complaint, the commissioner shall send by registered or certified mail, return receipt requested, a copy of such proposed complaint to each health care provider named as a defendant at such provider's last-known place of residence or business. The filing of a proposed complaint with the Insurance Commissioner shall toll the applicable statute of limitations until sixty days after the date the claimant receives a copy of the hearing panel's finding pursuant to section 38a-36, as amended by this act, or the hearing panel's decision dismissing the claim.

(c) Whenever **[**all parties to a claim for malpractice agree, they may request the Insurance Commissioner or his designee to**]** a proposed complaint is filed with the Insurance Commissioner pursuant to subsection (b) of this section, the commissioner or the commissioner's designee shall, not later than thirty days after such filing, select a hearing panel composed of **[**two physicians**]** two health care providers and one attorney from the Malpractice Screening Panel established under section 38a-32, as amended by this act. None of the members of the hearing panel, insofar as possible, shall be from the same community of practice of either the **[**physician**]** health care provider involved or the attorneys for the parties. **[**At least one of the

physicians**]** One health care provider member shall be from the same profession or specialty as the **[**physician**]** health care provider against whom such claim is filed and the other health care provider member shall be from a hospital, outpatient surgical facility or outpatient clinic. The attorney shall have experience in the trial of personal injury cases. **[**The attorney so designated shall act as chairman.**]** Upon the filing of such proposed complaint, the Insurance Commissioner shall notify the Chief Court Administrator and the Chief Court Administrator shall, not later than thirty days after such notice, select a judge trial referee to be a member of the hearing panel and serve as chairperson of the hearing panel. Whenever deemed necessary due to the nature of the claim or the parties, the chairperson may select an additional member or members for the hearing panel from the Medical Malpractice Screening Panel established under section 38a-32, as amended by this act.

(d) For the purposes of this section, "health care provider" means any person, corporation, facility or institution licensed by this state to provide health care or professional services, or an officer, employee or agent thereof acting in the course and scope of his or her employment.

Sec. 3. Section 38a-34 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The hearing panel so selected shall decide when and at what place it will hold its hearings. A transcript of the proceedings may be taken at the discretion of either or both parties and the expense of the same shall be borne by the party ordering the same or desiring a copy thereof. The original of **[**said**]** the transcript and all pertinent records of **[**said**]** the panel shall be maintained by the Insurance Commissioner.

Sec. 4. Section 38a-35 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) All proceedings, records, findings and deliberations of a hearing panel shall be confidential and shall not be used in any other proceedings, or otherwise publicized, except as provided in section

19a-17b and sections 38a-32 to 38a-36, inclusive, **[**nor**]** as amended by this act, or disclosed by any party, witness, counsel, panel member or other person, on penalty of being found in contempt of court.

(b) No person who provides testimony or information to a hearing panel on any matter submitted to it shall, without a showing of malice, be personally liable for any damages resulting from such testimony or information.

(c) The manner in which a hearing panel and each member thereof deliberates, decides and votes on any matter submitted to it, including whether its final decision is unanimous or otherwise, shall not be disclosed or made public by any person, except as provided in **[**said sections**]** section 19a-17b and sections 38a-32 to 38a-36, inclusive, as amended by this act.

Sec. 5. Section 38a-36 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

At the conclusion of its hearing and deliberation, the hearing panel shall make a finding as to liability only signed by all members and record the same with the Insurance Commissioner who shall forward a copy of the same to the parties. The finding, if unanimous, shall be admissible in evidence at any subsequent trial of the issues. The trier, whether court or jury, shall determine what if any weight should be afforded **[**said**]** the finding. The finding shall speak for itself and no member of the panel shall be subject to subpoena or required to testify regarding the same. Any explanation of the finding **[**or**]** of the panel shall be at the discretion of the trial judge.

Sec. 6. Section 52-190a of the general statutes, as amended by section 14 of public act 03-202, is repealed and the following is substituted in lieu thereof (*Effective from passage and applicable to actions filed on or after said date*):

(a) No civil action shall be filed to recover damages resulting from personal injury or wrongful death occurring on or after October 1,

1987, whether in tort or in contract, in which it is alleged that such injury or death resulted from the negligence of a health care provider, unless the attorney or party filing the action has made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. The complaint or initial pleading shall contain a certificate of the attorney or party filing the action that such reasonable inquiry gave rise to a good faith belief that grounds exist for an action against each named defendant. **[**For the purposes of this section, such good faith may be shown to exist if the claimant or his attorney has received a written opinion, which shall not be subject to discovery by any party except for questioning the validity of the certificate,**]** To show the existence of such good faith, the claimant or the claimant's attorney shall obtain a written and signed opinion of a similar health care provider, as defined in section 52-184c, which similar health care provider shall be selected pursuant to the provisions of said section, that there appears to be evidence of medical negligence and includes a detailed basis for the formation of such opinion. Such written opinion shall not be subject to discovery by any party except for questioning the validity of the certificate. The claimant or the claimant's attorney shall retain the original written opinion and shall attach a copy of such written opinion, with the name and signature of the similar health care provider expunged, to such certificate. In addition to such written opinion, the court may consider other factors with regard to the existence of good faith. If the court determines, after the completion of discovery, that such certificate was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court upon motion or upon its own initiative shall impose upon the person who signed such certificate or a represented party, or both, an appropriate sanction which may include an order to pay to the other party or parties the amount of the reasonable expenses incurred because of the filing of the pleading, motion or other paper, including a reasonable attorney's fee. The court may also submit the matter to the appropriate authority for

disciplinary review of the attorney if the claimant's attorney submitted the certificate.

(b) Upon petition to the clerk of the court where the action will be filed, an automatic ninety-day extension of the statute of limitations shall be granted to allow the reasonable inquiry required by subsection (a) of this section. This period shall be in addition to other tolling periods.

Sec. 7. Section 19a-17a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) For purposes of this section, "terms of the award or settlement" means the rights and obligations of the parties to a medical malpractice claim, as determined by a court or by agreement of the parties, and shall include, but not be limited to, (1) for any individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383 who is a party to the claim, the type of healing art or other health care practice, and the specialty, if any, in which such individual engages, (2) the amount of the award or settlement, specifying the portion of the award or settlement attributable to economic damages and the portion of the award or settlement attributable to noneconomic damages, and (3) if there are multiple defendants, the allocation for payment of the award between or among such defendants.

(b) Upon the filing of any medical malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383, the plaintiff shall mail a copy of the complaint to the Department of Public Health.

(c) Upon entry of any medical malpractice award by any court or upon the parties entering a settlement of a malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383, the entity making payment on behalf of a party or, if no such entity exists, the party, shall **[**notify**]** provide to the Department of Public Health **[**of the terms of the award or settlement and shall provide to the department**]** and the Insurance Department a copy of

the award or settlement and the underlying complaint and answer, if any. Such copies provided to the Insurance Department shall not identify the parties to the claim. The Department of Public Health shall send the information received from such entity or party to the state board of examiners having cognizance over any individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383 who is a party to the claim. The **[**department**]** Department of Public Health shall review all medical malpractice claims and awards and all settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. On and after July 1, 2004, such review shall be conducted in accordance with guidelines adopted by the Department of Public Health, in accordance with the provisions of section 20-13b, as amended by this act, to determine the basis for such further investigation or disciplinary action. Any document received pursuant to this section shall not be considered a petition and shall not be subject to the provisions of section 1-210, as amended, unless the **[**department**]** Department of Public Health determines, following completion of its review, that further investigation or disciplinary action is warranted.

(d) No release of liability executed by a party to which payment is to be made under a settlement of a malpractice claim against an individual licensed pursuant to chapter 370 to 373, inclusive, 379 or 383 shall be effective until the attorney for the entity making payment on behalf of a party or, if no such entity exists, the attorney for the party, files with the court an affidavit stating that such attorney has provided the information required under subsection (c) of this section to the Department of Public Health and the Insurance Department.

(e) The Commissioner of Public Health and the Insurance Commissioner shall develop systems within their respective agencies for collecting, storing, utilizing, interpreting, reporting and providing public access to the information received under subsections (b) and (c) of this section. Each commissioner shall report the details of such systems within its agency to the joint standing committees of the General Assembly having cognizance of matters relating to public

health and insurance on or before July 1, 2004, in accordance with section 11-4a.

Sec. 8. Section 20-13b of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The Commissioner of Public Health, with advice and assistance from the board, may establish such regulations in accordance with chapter 54 as may be necessary to carry out the provisions of sections 20-13a to 20-13i, inclusive, as amended by this act. On or before July 1, 2004, such regulations shall include, but need not be limited to: (1) Guidelines for screening complaints received to determine which complaints will be investigated; (2) a prioritization system for conduct of investigations to ensure prompt action when it appears necessary; and (3) guidelines to determine when an investigation should be broadened beyond the initial complaint to include sampling patient records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations and additional interviews of patients and peers.

Sec. 9. Section 20-8a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) There shall be within the Department of Public Health a Connecticut Medical Examining Board. Said board shall consist of fifteen members appointed by the Governor, subject to the provisions of section 4-9a, as amended, in the manner prescribed for department heads in section 4-7, as follows: Five physicians practicing in the state; one physician who shall be a full-time member of the faculty of The University of Connecticut School of Medicine; one physician who shall be a full-time chief of staff in a general-care hospital in the state; one physician who shall be registered as a supervising physician for one or more physician assistants; one physician who shall be a graduate of a medical education program accredited by the American Osteopathic Association; one physician assistant licensed pursuant to section 20-12b and practicing in this state; and five public members. No

professional member of said board shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the board or have been such an officer during the year immediately preceding appointment or serve for more than two consecutive terms. Professional members shall be practitioners in good professional standing and residents of this state.

(b) All vacancies shall be filled by the Governor in the manner prescribed for department heads in section 4-7. Successors and appointments to fill a vacancy shall fulfill the same qualifications as the member succeeded or replaced. In addition to the requirements in sections 4-9a, as amended, and 19a-8, no person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in section 20-12a, shall be appointed as a public member.

(c) The Commissioner of Public Health shall establish a list of eighteen persons who may serve as members of medical hearing panels established pursuant to subsection (g) of this section. Persons appointed to the list shall serve as members of the medical hearing panels and provide the same services as members of the Connecticut Medical Examining Board. Members from the list serving on such panels shall not be voting members of the Connecticut Medical Examining Board. The list shall consist of eighteen members appointed by the commissioner, eight of whom shall be physicians, as defined in section 20-13a, with at least one of such physicians being a graduate of a medical education program accredited by the American Osteopathic Association, one of whom shall be a physician assistant licensed pursuant to section 20-12b, and nine of whom shall be members of the public. No professional member of the list shall be an elected or appointed officer of a professional society or association relating to such member's profession at the time of appointment to the list or have been such an officer during the year immediately preceding such appointment to the list. A licensed professional appointed to the list shall be a practitioner in good professional standing and a resident of

this state. All vacancies shall be filled by the commissioner. Successors and appointments to fill a vacancy on the list shall possess the same qualifications as those required of the member succeeded or replaced. No person whose spouse, parent, brother, sister, child or spouse of a child is a physician, as defined in section 20-13a, or a physician assistant, as defined in section 20-12a, shall be appointed to the list as a member of the public. Each person appointed to the list shall serve without compensation at the pleasure of the commissioner.

(d) The office of the board shall be in Hartford, in facilities to be provided by the department.

(e) The board shall adopt and may amend a seal.

(f) The Governor shall appoint a chairperson from among the board members. Said board shall meet at least once during each calendar quarter and at such other times as the chairperson deems necessary. Special meetings shall be held on the request of a majority of the board after notice in accordance with the provisions of section 1-225. A majority of the members of the board shall constitute a quorum. Members shall not be compensated for their services. Any member who fails to attend three consecutive meetings or who fails to attend fifty per cent of all meetings held during any calendar year shall be deemed to have resigned from office. Minutes of all meetings shall be recorded by the board. No member shall participate in the affairs of the board during the pendency of any disciplinary proceedings by the board against such member. Said board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints against practitioners, and (3) impose sanctions where appropriate.

(g) (1) Not later than December 31, 2004, the board, with the assistance of the department, shall adopt regulations, in accordance with chapter 54, to establish guidelines for use in the disciplinary process. Such guidelines shall include, but need not be limited to: (A) Identification of each type of violation; (B) a minimum and maximum penalty for each type of violation; (C) additional optional conditions

that may be imposed by the board for each violation; (D) identification of factors the board shall consider in determining if the maximum or minimum penalty should apply; (E) conditions, such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (F) a provision that when a deviation from the guidelines occurs, the reason for the deviation shall be identified.

(2) The board shall refer all statements of charges filed with the board by the department pursuant to section 20-13e, as amended by this act, to a medical hearing panel established pursuant to subdivision (4) of this subsection within sixty days of the receipt of charges. This time period may be extended for good cause by the board in a duly recorded vote. **[**The panel shall consist of three members, at least one of whom shall be a member of the board and one a member of the public. The public member may be a member of either the board or of the list established pursuant to subsection (c) of this section.**]** The panel shall conduct a hearing, in accordance with the provisions of chapter 54, and the regulations established by the Commissioner of Public Health concerning contested cases, except that the panel shall file a proposed final decision with the board within one hundred twenty days of the receipt of the issuance of the notice of hearing by the board. The time period for filing such proposed final decision with the board may be extended for good cause by the board in a duly recorded vote. If the panel has not conducted a hearing within sixty days of the date of referral of the statement of charges by the board, such hearing shall be conducted by the commissioner, in accordance with the provisions of chapter 54, and the regulations established by the commissioner concerning contested cases. The commissioner shall file a proposed final decision with the board not later than sixty days after such hearing. The time period for filing such proposed final decision with the board may be extended for good cause by the board in a duly recorded vote.

(3) The board shall refer all findings of no probable cause filed with the board by the department pursuant to section 20-13e, as amended by this act, to a medical hearing panel within sixty days of the receipt

of charges. This time period may be extended for good cause by the board in a duly recorded vote. The panel shall review the petition and the entire record of the investigation and may request the department for more information or for a reconsideration of such finding. If the panel takes no action within ninety days of the submission to the board of such finding, the department's finding of no probable cause shall be considered final.

(4) For purposes of this section, a medical hearing panel shall consist of three members, at least one of whom shall be a member of the Connecticut Medical Examining Board and one a member of the public. The public member may be a member of either the board or of the list established pursuant to subsection (c) of this section.

(h) The board shall review the panel's proposed final decision in accordance with the provisions of section 4-179, and adopt, modify or remand said decision for further review or for the taking of additional evidence. The board shall act on the proposed final decision within ninety days of the filing of said decision by the panel. This time period may be extended by the board for good cause in a duly recorded vote.

(i) Except in a case in which a license has been summarily suspended, pursuant to subsection (c) of section 19a-17 or subsection (c) of section 4-182, all three panel members shall be present to hear any evidence and vote on a proposed final decision. The chairperson of the Medical Examining Board may exempt a member from a meeting of the panel if the chairperson finds that good cause exists for such an exemption. Such an exemption may be granted orally but shall be reduced to writing and included as part of the record of the panel within two business days of the granting of the exemption or the opening of the record and shall state the reason for the exemption. Such exemption shall be granted to a member no more than once during any contested case and shall not be granted for a meeting at which the panel is acting on a proposed final decision on a statement of charges. The board may appoint a member to the panel to replace any member who resigns or otherwise fails to continue to serve on the

panel. Such replacement member shall review the record prior to the next hearing.

(j) A determination of good cause shall not be reviewable and shall not constitute a basis for appeal of the decision of the board pursuant to section 4-183.

Sec. 10. Section 20-13i of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

The department shall file with the Governor and the joint standing committee on public health of the General Assembly on or before January 1, 1986, and thereafter on or before January first of each succeeding year, a report of the activities of the department and the board conducted pursuant to sections 20-13d and 20-13e, as amended by this act. Each such report shall include, but shall not be limited to, the following information: The number of petitions received; the number of petitions not investigated, and the reasons why; the number of hearings held on such petitions; **[**and,**]** the outcome of such hearings; the timeliness of action taken on any petition considered to be a priority; without identifying the particular physician concerned, a brief description of the impairment alleged in each such petition and the actions taken with regard to each such petition by the department and the board; the number of notifications received pursuant to section 19a-17a, as amended by this act; the number of such notifications with no further action taken, and the reasons why; and the outcomes for notifications where further action is taken.

Sec. 11. (NEW) (*Effective from passage*) (a) Each licensed hospital or outpatient surgical facility shall establish protocols for screening patients prior to any surgery. Such protocols shall require that: (1) Prior to any surgery, members of the surgical team, including at least one principal surgeon, but not exceeding five such members in total, together (A) identify the patient and, where the patient is able to do so, have the patient identify himself or herself, and (B) identify the procedure to be performed, and (2) no patient may be anesthetized and no surgery may be performed unless the identifications specified

in subdivision (1) of this subsection have been confirmed by all such members, except that such protocols may provide for alternative identification procedures where the patient is unconscious or under emergency circumstances. Each licensed hospital or outpatient surgical facility shall annually submit to the Department of Public Health a copy of such protocols and a report on their implementation.

(b) The Department of Public Health shall assist each hospital or outpatient surgical facility with the development and implementation of the screening protocols required under subsection (a) of this section.

Sec. 12. Section 52-192a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) After commencement of any civil action based upon contract or seeking the recovery of money damages, whether or not other relief is sought, the plaintiff may, not later than thirty days before trial, file with the clerk of the court a written "offer of judgment" signed by the plaintiff or the plaintiff's attorney, directed to the defendant or the defendant's attorney, offering to settle the claim underlying the action and to stipulate to a judgment for a sum certain. The plaintiff shall give notice of the offer of settlement to the defendant's attorney or, if the defendant is not represented by an attorney, to the defendant himself or herself. Within sixty days after being notified of the filing of the "offer of judgment" or within any extension or extensions thereof, not to exceed a total of one hundred twenty additional days, granted by the court for good cause shown, and prior to the rendering of a verdict by the jury or an award by the court, the defendant or the defendant's attorney may file with the clerk of the court a written "acceptance of offer of judgment" agreeing to a stipulation for judgment as contained in plaintiff's "offer of judgment". Upon such filing, the clerk shall enter judgment immediately on the stipulation. If the "offer of judgment" is not accepted within **[**sixty days**]** the sixty-day period or any extension thereof, and prior to the rendering of a verdict by the jury or an award by the court, the "offer of judgment" shall be considered rejected and not subject to acceptance unless refiled. Any such "offer of judgment"

and any "acceptance of offer of judgment" shall be included by the clerk in the record of the case.

(b) After trial the court shall examine the record to determine whether the plaintiff made an "offer of judgment" which the defendant failed to accept. If the court ascertains from the record that the plaintiff has recovered an amount equal to or greater than the sum certain stated in the plaintiff's "offer of judgment", the court shall add to the amount so recovered twelve per cent annual interest on said amount, **[**computed from the date such offer was filed in actions commenced before October 1, 1981. In those actions commenced on or after October 1, 1981, the**]** with respect to an offer of judgment filed prior to the effective date of this section, and interest at an annual rate of four percentage points above the weekly average five-year constant maturity yield of United States Treasury securities, as published by the Board of Governors of the Federal Reserve System, for the calendar week preceding the beginning of each year for which interest is owed, with respect to an offer of judgment filed on or after the effective date of this section. The interest shall be computed from the date the complaint in the civil action was filed with the court if the "offer of judgment" was filed not later than eighteen months from the filing of such complaint. If such offer was filed later than eighteen months from the date of filing of the complaint, the interest shall be computed from the date the "offer of judgment" was filed. The court may award reasonable attorney's fees in an amount not to exceed three hundred fifty dollars, and shall render judgment accordingly. This section shall not be interpreted to abrogate the contractual rights of any party concerning the recovery of attorney's fees in accordance with the provisions of any written contract between the parties to the action.

Sec. 13. Section 38a-393 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2004*):

(a) Each insurance company doing business in this state shall, annually, on or before the first day of March, render to the Insurance Commissioner a true record of the number, according to classification,

of cancellations of and refusals to renew professional liability insurance policies for the year ending on the thirty-first day of December next preceding.

(b) For purposes of sections 38a-393 to 38a-395, inclusive, as amended by this act, "professional liability insurance" means professional liability contracts for: (1) Physicians and surgeons, (2) hospitals, (3) lawyers, (4) dentists, (5) architects and engineers, (6) chiropractors, (7) licensed natureopaths, (8) podiatrists, and (9) advanced practice registered nurses and such other categories as the Insurance Commissioner, in the commissioner's discretion, shall adopt by regulations in accordance with chapter 54.

(c) Each insurance company that issues a property and casualty policy in this state and issues a medical malpractice policy in any state, district or territory of the United States shall offer for sale professional liability insurance policies for: (1) Physicians and surgeons, (2) hospitals, (3) dentists, (4) chiropractors, (5) licensed natureopaths, (6) podiatrists, (7) advanced practice registered nurses, and (8) such other categories as the Insurance Commissioner adopts pursuant to subsection (b) of this section related to medical professionals or entities.

Sec. 14. Subsection (a) of section 20-13e of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) (1) The department shall investigate each petition filed pursuant to section 20-13d, in accordance with the provisions of subdivision (10) of subsection (a) of section 19a-14, to determine if probable cause exists to issue a statement of charges and to institute proceedings against the physician under subsection (e) of this section. Such investigation shall be concluded not later than eighteen months from the date the petition is filed with the department and, unless otherwise specified by this subsection, the record of such investigation shall be deemed a public record, in accordance with section 1-210, as amended, at the conclusion of such eighteen-month period. Any such investigation shall be

confidential and no person shall disclose his knowledge of such investigation to a third party unless the physician requests that such investigation and disclosure be open. If the department determines that probable cause exists to issue a statement of charges, the entire record of such proceeding shall be public unless the department determines that the physician is an appropriate candidate for participation in a rehabilitation program in accordance with subsection (b) of this section and the physician agrees to participate in such program in accordance with terms agreed upon by the department and the physician. If at any time subsequent to the filing of a petition and during the eighteen-month period, the department makes a finding of no probable cause and the medical panel appointed pursuant to subsection (g) of section 20-8a, as amended by this act, allows such finding to stand, the petition and the entire record of such investigation shall remain confidential unless the physician requests that such petition and record be open.

(2) The department shall notify the person who filed the petition or such person's legal representative at such time as the department makes a finding of no probable cause, and include the reason for such finding.

Sec. 15. Subsection (b) of section 19a-88 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(b) Each person holding a license to practice medicine, surgery, podiatry, chiropractic or natureopathy shall, annually, during the month of such person's birth, register with the Department of Public Health, upon payment of the professional services fee for class I, as defined in section 33-182l, on blanks to be furnished by the department for such purpose, giving such person's name in full, such person's residence and business address, the name of the insurance company providing such person's professional liability insurance and the policy number of such insurance, such person's area of specialization, whether such person is actively involved in patient care, any

disciplinary action against such person, or malpractice payments made on behalf of such person in any other state or jurisdiction, and such other information as the department requests. The department may compare information submitted pursuant to this subsection to information contained in the National Practitioner Data Base.

Sec. 16. (NEW) (*Effective from passage*) On or before January 1, 2005, and annually thereafter, the Department of Public Health shall report, in accordance with section 11-4a of the general statutes, the number of physicians by specialty who are actively providing patient care.

Sec. 17. (NEW) (*Effective July 1, 2004*) Each insurer that delivers, issues for delivery or renews in this state a professional liability insurance policy for a medical professional or entity shall offer a premium discount on the policy to any insured who submits to the insurer proof that the insured will use an electronic health record system during the premium period to establish and maintain patient records and verify patient treatment. Such discount shall be not less than twenty per cent of the premium for a period of one year from the effective date of the policy or renewal.

Sec. 18. (NEW) (*Effective July 1, 2004*) The Connecticut Health and Educational Facilities Authority shall establish a program, within available appropriations, to finance low interest loans to hospitals to install or upgrade electronic health record systems for the establishment and maintenance of patient records and verification of patient treatment. The program shall be known as the Connecticut Electronic Health Records Program. Loans shall be made for the purpose of establishing or upgrading electronic health record systems for use by hospitals in order to promote patient safety and eliminate errors.

Sec. 19. Section 38a-676 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) With respect to rates pertaining to commercial risk insurance, and subject to the provisions of subsection (b) of this section with

respect to workers' compensation and employers' liability insurance and certain professional liability insurance, on or before the effective date [thereof, every] of such rates, each admitted insurer shall submit to the Insurance Commissioner for the commissioner's information, except as to inland marine risks which by general custom of the business are not written according to manual rates or rating plans, [every] each manual of classifications, rules and rates, and [every] each minimum, class rate, rating plan, rating schedule and rating system and any modification of the foregoing which it uses. Such submission by a licensed rating organization of which an insurer is a member or subscriber shall be sufficient compliance with this section for any insurer maintaining membership or subscribership in such organization, to the extent that the insurer uses the manuals, minimums, class rates, rating plans, rating schedules, rating systems, policy or bond forms of such organization. The information shall be open to public inspection after its submission.

(b) (1) Each filing as described in subsection (a) of this section for workers' compensation or employers' liability insurance shall be on file with the Insurance Commissioner for a waiting period of thirty days before it becomes effective, which period may be extended by the commissioner for an additional period not to exceed thirty days if the commissioner gives written notice within such waiting period to the insurer or rating organization which made the filing that the commissioner needs such additional time for the consideration of such filing. Upon written application by such insurer or rating organization, the commissioner may authorize a filing which the commissioner has reviewed to become effective before the expiration of the waiting period or any extension thereof. A filing shall be deemed to meet the requirements of sections 38a-663 to 38a-696, inclusive, unless disapproved by the commissioner within the waiting period or any extension thereof. If, within the waiting period or any extension thereof, the commissioner finds that a filing does not meet the requirements of said sections, the commissioner shall send to the insurer or rating organization which made such filing written notice of

disapproval of such filing, specifying therein in what respects the commissioner finds such filing fails to meet the requirements of said sections and stating that such filing shall not become effective. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(2) Each filing as described in subsection (a) of this section for professional liability insurance for physicians and surgeons, hospitals or advanced practice registered nurses shall be subject to prior rate approval in accordance with this section. On and after the effective date of this section, each insurer or rating organization seeking to change its rates for such insurance shall (A) file a request for such change with the Insurance Department, and (B) provide written notice to its insureds with respect to any request for an increase in rates. Such request shall be filed and such notice, if applicable, shall be sent at least sixty days prior to the proposed effective date of the change. The notice to insureds of a request for an increase in rates shall indicate that a public hearing shall be held in accordance with this section. The Insurance Department shall review the request and, with respect to a request for an increase in rates, shall hold a public hearing on such increase prior to approving or denying the request. The Insurance Commissioner shall approve or deny the request within forty-five days of its receipt. Such finding of the commissioner shall be subject to review as provided in section 38a-19.

(c) The form of any insurance policy or contract the rates for which are subject to the provisions of sections 38a-663 to 38a-696, inclusive, other than fidelity, surety or guaranty bonds, and the form of any endorsement modifying such insurance policy or contract, shall be filed with the Insurance Commissioner prior to its issuance. The commissioner shall adopt regulations, in accordance with the provisions of chapter 54, establishing a procedure for review of such policy or contract. If at any time the commissioner finds that any such policy, contract or endorsement is not in accordance with such provisions or any other provision of law, the commissioner shall issue an order disapproving the issuance of such form and stating the

reasons for disapproval. The provisions of section 38a-19 shall apply to any such order issued by the commissioner.

Sec. 20. (NEW) (*Effective October 1, 2004*) (a) On and after October 1, 2004, no captive insurer, as defined in section 38a-91 of the general statutes, may insure a health care provider or entity in this state against liability for medical malpractice unless the captive insurer has obtained a certificate of authority from the Insurance Commissioner, except that no certificate of authority shall be required for any captive insurer that is duly licensed in this state to offer such insurance.

(b) Any captive insurer seeking to obtain a certificate of authority shall make application to the commissioner, on such form as the commissioner requires, setting forth the line or lines of business which it is seeking authorization to write. The captive insurer shall file with the commissioner a certified copy of its charter or articles of association and evidence satisfactory to the commissioner that it has complied with the laws of the jurisdiction under which it is organized, a statement of its financial condition in such form as is required by the commissioner, together with such evidence of its correctness as the commissioner requires and evidence of good management in such form as is required by the commissioner. The captive insurer shall submit evidence of its ability to provide continuous and timely claims settlement. If the information furnished is satisfactory to the commissioner, and if all other requirements of law have been complied with, the commissioner may issue to such insurer a certificate of authority permitting it to do business in this state. Each such certificate of authority shall expire on the first day of May succeeding the date of its issuance, but may be renewed without any formalities except as required by the commissioner. Failure of a captive insurer to exercise its authority to write a particular line or lines of business in this state for two consecutive calendar years may constitute sufficient cause for revocation of the captive insurer's authority to write those lines of business.

(c) The commissioner shall adopt regulations, in accordance with

chapter 54 of the general statutes, specifying the information and evidence that a captive insurer seeking to obtain or renew a certificate of authority shall submit and the requirements with which it shall comply.

(d) The commissioner may, at any time, for cause, suspend, revoke or refuse to renew any such certificate of authority or in lieu of or in addition to suspension or revocation of such certificate of authority the commissioner, after reasonable notice to and hearing of any holder of such certificate of authority, may impose a fine not to exceed ten thousand dollars. Such hearings may be held by the commissioner or any person designated by the commissioner. Whenever a person other than the commissioner acts as the hearing officer, the person shall submit to the commissioner a memorandum of findings and recommendations upon which the commissioner may base a decision. The commissioner may, if the commissioner deems it in the interest of the public, publish in one or more newspapers of the state a statement that, under the provisions of this section, the commissioner has suspended or revoked the certificate of authority of any captive insurer to do business in this state.

(e) Each application for a certificate of authority shall be accompanied by a nonrefundable fee as set forth in section 38a-11 of the general statutes, as amended by this act. All expenses incurred by the commissioner in connection with proceedings under this section shall be paid by the person filing the application.

(f) Any captive insurer aggrieved by the action of the commissioner in revoking, suspending or refusing to renew a certificate of authority or in imposing a fine may appeal therefrom, in accordance with the provisions of section 4-183 of the general statutes, except venue for such appeal shall be in the judicial district of New Britain. Appeals under this section shall be privileged in respect to the order of trial assignment.

Sec. 21. Subsection (a) of section 38a-11 of the general statutes, as amended by section 10 of public act 03-152 and section 9 of public act

03-169, is repealed and the following is substituted in lieu thereof (*Effective October 1, 2004*):

(a) The commissioner shall demand and receive the following fees: (1) For the annual fee for each license issued to a domestic insurance company, one hundred dollars; (2) for receiving and filing annual reports of domestic insurance companies, twenty-five dollars; (3) for filing all documents prerequisite to the issuance of a license to an insurance company, one hundred seventy-five dollars, except that the fee for such filings by any health care center, as defined in section 38a-175, shall be one thousand one hundred dollars; (4) for filing any additional paper required by law, fifteen dollars; (5) for each certificate of valuation, organization, reciprocity or compliance, twenty dollars; (6) for each certified copy of a license to a company, twenty dollars; (7) for each certified copy of a report or certificate of condition of a company to be filed in any other state, twenty dollars; (8) for amending a certificate of authority, one hundred dollars; (9) for each license issued to a rating organization, one hundred dollars. In addition, insurance companies shall pay any fees imposed under section 12-211; (10) a filing fee of twenty-five dollars for each initial application for a license made pursuant to section 38a-769; (11) with respect to insurance agents' appointments: (A) A filing fee of twenty-five dollars for each request for any agent appointment; (B) a fee of forty dollars for each appointment issued to an agent of a domestic insurance company or for each appointment continued; and (C) a fee of twenty dollars for each appointment issued to an agent of any other insurance company or for each appointment continued, except that no fee shall be payable for an appointment issued to an agent of an insurance company domiciled in a state or foreign country which does not require any fee for an appointment issued to an agent of a Connecticut insurance company; (12) with respect to insurance producers: (A) An examination fee of seven dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued; and (C) a fee of forty dollars for each license renewed;

(13) with respect to public adjusters: (A) An examination fee of seven dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of seven dollars to the commissioner for each examination taken by an applicant; and (B) a fee of one hundred twenty-five dollars for each license issued or renewed; (14) with respect to casualty adjusters: (A) An examination fee of ten dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (15) with respect to motor vehicle physical damage appraisers: (A) An examination fee of forty dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of forty dollars to the commissioner for each examination taken by an applicant; (B) a fee of forty dollars for each license issued or renewed; and (C) the expense of any examination administered outside the state shall be the responsibility of the entity making the request and such entity shall pay to the commissioner one hundred dollars for such examination and the actual traveling expenses of the examination administrator to administer such examination; (16) with respect to certified insurance consultants: (A) An examination fee of thirteen dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of thirteen dollars to the commissioner for each examination taken by an applicant; (B) a fee of two hundred dollars for each license issued; and (C) a fee of one hundred twenty-five dollars for each license renewed; (17) with respect to surplus lines brokers: (A) An examination fee of ten dollars for each examination taken, except when a testing service is used, the testing service shall pay a fee of ten dollars to the commissioner for each examination taken by an applicant; and (B) a fee of five hundred dollars for each license issued

or renewed; (18) with respect to fraternal agents, a fee of forty dollars for each license issued or renewed; (19) a fee of thirteen dollars for each license certificate requested, whether or not a license has been issued; (20) with respect to domestic and foreign benefit societies shall pay: (A) For service of process, twenty-five dollars for each person or insurer to be served; (B) for filing a certified copy of its charter or articles of association, five dollars; (C) for filing the annual report, ten dollars; and (D) for filing any additional paper required by law, three dollars; (21) with respect to foreign benefit societies: (A) For each certificate of organization or compliance, four dollars; (B) for each certified copy of permit, two dollars; and (C) for each copy of a report or certificate of condition of a society to be filed in any other state, four dollars; (22) with respect to reinsurance intermediaries: A fee of five hundred dollars for each license issued or renewed; (23) with respect to viatical settlement providers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a, as amended; and (B) a fee of twenty dollars for each license issued or renewed; (24) with respect to viatical settlement brokers: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a, as amended; and (B) a fee of twenty dollars for each license issued or renewed; (25) with respect to viatical settlement investment agents: (A) A filing fee of thirteen dollars for each initial application for a license made pursuant to section 38a-465a, as amended; and (B) a fee of twenty dollars for each license issued or renewed; (26) with respect to preferred provider networks, a fee of two thousand five hundred dollars for each license issued or renewed; (27) with respect to rental companies, as defined in section 38a-799, a fee of forty dollars for each permit issued or renewed; (28) with respect to a certificate of authority for a captive insurer pursuant to section 20 of this act, a fee of one hundred seventy-five dollars for each certificate issued or renewed; and **[**(28)**]** (29) with respect to each duplicate license issued a fee of twenty-five dollars for each license issued.

Sec. 22. (NEW) (*Effective from passage*) Any party to an action for medical malpractice may file an application with the Superior Court requesting that the case be designated as a complex litigation case and

be transferred by the Chief Court Administrator or any judge designated by the Chief Court Administrator to the complex litigation docket in a judicial district and court location determined by the Chief Court Administrator or such designee.

Sec. 23. Section 52-251c of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(a) In any claim or civil action to recover damages resulting from personal injury, wrongful death or damage to property occurring on or after October 1, 1987, the attorney and the claimant may provide by contract, which contract shall comply with all applicable provisions of the rules of professional conduct governing attorneys adopted by the judges of the Superior Court, that the fee for the attorney shall be paid contingent upon, and as a percentage of: (1) Damages awarded and received by the claimant; or (2) settlement amount pursuant to a settlement agreement.

(b) In any such contingency fee arrangement such fee shall be the exclusive method for payment of the attorney by the claimant and shall not exceed an amount equal to a percentage of the damages awarded and received by the claimant or of the settlement amount received by the claimant as follows: (1) Thirty-three and one-third per cent of the first three hundred thousand dollars; (2) twenty-five per cent of the next three hundred thousand dollars; (3) twenty per cent of the next three hundred thousand dollars; (4) fifteen per cent of the next three hundred thousand dollars; and (5) ten per cent of any amount which exceeds one million two hundred thousand dollars.

(c) Whenever a claimant in a medical malpractice case enters into a contingency fee arrangement with an attorney which provides for a fee that would exceed the percentage limitations set forth in subsection (b) of this section, such arrangement shall not be valid unless the claimant's attorney files an application with the court for approval of such arrangement and the court, after a hearing, grants such application. The claimant's attorney shall attach to such application a copy of such fee arrangement and the proposed unsigned writ,

summons and complaint in the case. The court shall grant such application if it finds that the case is sufficiently complex, unique or different from other medical malpractice cases so as to warrant a deviation from such percentage limitations. At such hearing, the claimant's attorney shall have the burden of showing that such deviation is warranted. If the court does not grant such application, it shall advise the claimant of the claimant's right to seek representation by another attorney willing to abide by the percentage limitations set forth in subsection (b) of this section. The filing of such application shall toll the applicable statute of limitations for a period of ninety days.

[(c)**]** (d) For the purposes of this section, "damages awarded and received" means in a civil action in which final judgment is entered, that amount of the judgment or amended judgment entered by the court that is received by the claimant after deduction for any disbursements or costs incurred by the attorney in connection with the prosecution or settlement of the civil action, other than ordinary office overhead and expense, for which the claimant is liable, except that in a civil action brought pursuant to section 38a-368 such amount shall be further reduced by any basic reparations benefits paid to the claimant pursuant to section 38a-365; and "settlement amount received" means in a claim or civil action in which no final judgment is entered, the amount received by the claimant pursuant to a settlement agreement after deduction for any disbursements or costs incurred by the attorney in connection with the prosecution or settlement of the claim or civil action, other than ordinary office overhead and expense, for which the claimant is liable, except that in a claim or civil action brought pursuant to section 38a-368 such amount shall be further reduced by any basic reparations benefits paid to the claimant pursuant to section 38a-365. **[**; and "fee" shall not include disbursements or costs incurred in connection with the prosecution or settlement of the claim or civil action, other than ordinary office overhead and expense.**]**

Sec. 24. Section 38a-395 of the general statutes is repealed and the

following is substituted in lieu thereof (*Effective January 1, 2005*):

[The Insurance Commissioner may require all insurance companies writing medical malpractice insurance in this state to submit, in such manner and at such times as he specifies, such information as he deems necessary to establish a data base on medical malpractice, including information on all incidents of medical malpractice, all settlements, all awards, other information relative to procedures and specialties involved and any other information relating to risk management.**]**

(a) As used in this section:

(1) "Claim" means a request for indemnification filed by a medical professional or entity pursuant to a professional liability policy for a loss for which a reserve amount has been established by an insurer;

(2) "Closed claim" means a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on the claim; and

(3) "Insurer" means an insurer, as defined in section 38a-1, as amended, that insures a medical professional or entity against professional liability. Insurer includes, but is not limited to, a captive insurer or a self-insured person.

(b) On and after January 1, 2005, each insurer shall provide to the Insurance Commissioner a closed claim report, on such form as the commissioner requires, in accordance with this section. The insurer shall submit the report not later than ten days after the last day of the calendar quarter in which a claim for recovery under a medical liability policy is closed. The report shall only include information about claims settled under the laws of this state.

(c) The closed claim report shall include:

(1) Details about the insured and insurer, including: (A) The name of the insurer; (B) the professional liability insurance policy limits and

whether the policy was an occurrence policy or was issued on a claims-made basis; (C) the name, address, health care provider professional license number and specialty coverage of the insured; and (D) the insured's policy number and a unique claim number.

(2) Details about the injury or loss, including: (A) The date of the injury or loss that was the basis of the claim; (B) the date the injury or loss was reported to the insurer; (C) the name of the institution or location at which the injury or loss occurred; (D) the type of injury or loss, including a severity of injury rating that corresponds with the severity of injury scale that the Insurance Commissioner shall establish based on the severity of injury scale developed by the National Association of Insurance Commissioners; and (E) the name, age and gender of any injured person covered by the claim. Any individually identifiable information submitted pursuant to this subdivision shall be confidential.

(3) Details about the claims process, including: (A) Whether a lawsuit was filed, and if so, in which court; (B) the outcome of such lawsuit; (C) the number of other defendants, if any; (D) the stage in the process when the claim was closed; (E) the dates of the trial; (F) the date of the judgment or settlement, if any; (G) whether an appeal was filed, and if so, the date filed; (H) the resolution of the appeal and the date such appeal was decided; (I) the date the claim was closed; (J) the initial indemnity and expense reserve for the claim; and (K) the final indemnity and expense reserve for the claim.

(4) Details about the amount paid on the claim, including: (A) The total amount of the initial judgment rendered by a jury or awarded by the court; (B) the total amount of the settlement if there was no judgment rendered or awarded; (C) the total amount of the settlement if the claim was settled after judgment was rendered or awarded; (D) the amount of economic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (E) the amount of noneconomic damages, as defined in section 52-572h, or the insurer's estimate of the amount in the event of a settlement; (F) the

amount of any interest awarded due to failure to accept an offer of judgment; (G) the amount of any remittitur or additur; (H) the amount of final judgment after remittitur or additur; (I) the amount paid by the insurer; (J) the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits; (K) the amount paid by other insurers; (L) the amount paid by other defendants; (M) whether a structured settlement was used; (N) the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and (O) any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to medical professionals and entities, ensure the industry's solvency and ensure that such liability insurance is available and affordable.

(d) (1) The commissioner shall establish an electronic database composed of closed claim reports filed pursuant to this section.

(2) The commissioner shall compile the data included in individual closed claim reports into an aggregated, summary format and shall prepare a written annual report of the summary data. The report shall provide an analysis of closed claim information including a minimum of five years of comparative data, when available, trends in frequency and severity of claims, itemization of damages, timeliness of the claims process, and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

(3) The annual report shall include a summary of rate filings for professional liability insurance for medical professionals and entities which have been approved by the department for the prior calendar year, including an analysis of the trend of direct losses, incurred losses, earned premiums and investment income as compared to prior years. The report shall include base premiums charged by medical malpractice insurers for each specialty and the number of providers insured by specialty for each insurer.

(4) Not later than March 15, 2006, and annually thereafter, the

commissioner shall submit the annual report to the joint standing committee of the General Assembly having cognizance of matters relating to insurance in accordance with section 11-4a. The commissioner shall also (A) make the report available to the public, (B) post the report on its Internet site, and (C) provide public access to the contents of the electronic database after the commissioner establishes that the names and other individually identifiable information about the claimant and practitioner have been removed.

(e) The Insurance Commissioner shall provide the Commissioner of Public Health with electronic access to all information received pursuant to this section.

This act shall take effect as follows:	
Section 1	*from passage*
Sec. 2	*from passage*
Sec. 3	*from passage*
Sec. 4	*from passage*
Sec. 5	*from passage*
Sec. 6	*from passage and applicable to actions filed on or after said date*
Sec. 7	*from passage*
Sec. 8	*from passage*
Sec. 9	*from passage*
Sec. 10	*from passage*
Sec. 11	*from passage*
Sec. 12	*from passage*
Sec. 13	*July 1, 2004*
Sec. 14	*from passage*
Sec. 15	*from passage*
Sec. 16	*from passage*
Sec. 17	*July 1, 2004*
Sec. 18	*July 1, 2004*
Sec. 19	*from passage*
Sec. 20	*October 1, 2004*
Sec. 21	*October 1, 2004*
Sec. 22	*from passage*
Sec. 23	*from passage*
Sec. 24	*January 1, 2005*

PRI *Joint Favorable Subst.*

The following fiscal impact statement and bill analysis are prepared for the benefit of members of the General Assembly, solely for the purpose of information, summarization, and explanation, and do not represent the intent of the General Assembly or either House thereof for any purpose:

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 04 $	FY 05$	FY 06$
Insurance Dept.	IF - Cost	9,100	55,000	55,000
Insurance Dept.	IF - Revenue Gain	Potential Minimal	Potential Minimal	Potential Minimal
Public Health, Dept.	GF - Cost	50,500	776,880	687,880
Public Health, Dept.	GF - Revenue Gain	Potential Minimal	Potential Minimal	Potential Minimal
UConn Health Ctr.	Various - Savings	Potential	Potential	Potential
Comptroller Misc. Accounts (Fringe Benefits)	GF - Cost	10,100	131,000	296,920
Connecticut Health and Educational Facilities Authority	CHEFA General Fund Balance - Commits reserve funds	See Below	See Below	See Below
Judicial Dept.	GF - Cost	Less than 50,000	Less than 50,000	Less than 300,000
Judicial Dept.	GF - Potential Savings	0	175,000	175,000

Note: IF=Insurance Fund; GF=General Fund

Municipal Impact: None

Explanation

This bill makes various changes related to medical malpractice reforms. Specific impacts are discussed below.

Sections 1 – 5 make use of the Insurance Department's pre-trial Medical Malpractice Screening Panel (MMSP) mandatory unless both parties agree to go directly to court. The Commissioner of Insurance would choose from the MMSP one attorney and two health care providers to serve on a hearing panel for each claim. In addition, the Chief Court Administrator must assign a judge trial referee to be a

member and serve as chairperson of the hearing panel. Members of the MMSP are not compensated. However, judge trial referees are paid $200 per day.

Up to 375 claims could be heard annually by these panels.[1] It is estimated that each of these additional cases could take up to four working days to dispose. The Judicial Department's annual cost to provide judge trial referees could therefore be as high as $300,000. Since the bill is effective upon passage, the FY 04 cost is estimated to be $50,000 (assuming May 1st enactment.) It is anticipated that hearing panel members will require transcripts of proceedings in order to make their findings of liability or dismiss claims. The associated, annual cost to the Department of Insurance (assuming 100 pp.) is estimated to be $55,000. The FY 04 pro rated cost is $9,167. There is also a minimal cost to the Department related to sending notice by registered or certified mail to health care providers named as defendants.

The institution of pre-trial hearing panels could substantially reduce the number of medical malpractice cases brought before the court. Limited data from the state of Maine (which has a similar program) indicate that eighty per cent of panels yield a unanimous finding, which typically precludes a jury trial. If Connecticut were to experience a similar result, an estimated annual savings of $175,000 could be achieved.

Section 6 requires a plaintiff or plaintiff's attorney to file a written and signed opinion by a similar health care provider in order to initiate a medical malpractice action. This additional requirement could reduce the number of medical malpractice cases brought before the Superior Court, and thereby decrease the workload of the Civil Division. Any such change would be small relative to the overall caseload since medical malpractice cases comprise less than one per

[1] An average of 375 medical malpractice cases have been filed with the Superior Court in each of the last five (complete) fiscal years.

cent of total civil cases added each year.[2] Consequently, there is no fiscal impact.

Section 7: Under the bill, the person who pays the damages must notify the Department of Insurance. This has no fiscal impact on the Department of Insurance.

Implementation of **Sections 7-9 and 14** will result in a significant cost to the Department of Public Health (DPH). The predominant reason for these costs is a requirement that the agency review and investigate when warranted all medical malpractice claims filed against a licensed physician, chiropractor, dentist or psychologist. Under current law, the agency reviews about 500 complaints and malpractice payment notices annually. Of these, about fifty percent (or 250) progress to an investigation. Under the bill, an additional 380 – 400 filed claims would require agency review each year, prompting an additional 190 – 200 investigations. The agency's Practitioner Investigations Unit currently has nine investigators.

The department's workload would also be increased to the extent that: (a) filed claims involve cases in which multiple medical practitioners are named, (b) the scope of reviews/investigations is broadened following adoption of regulations, and (c) medical review panels convened by the Connecticut Medical Examining Board (CMEB) ask for reconsideration of findings of no probable cause. (The agency dismisses about 240 cases each year concerning physicians following an investigation.)

Additional work would be associated with: (a) developing regulations, (b) notifying parties who have filed a petition questioning a physician's ability to practice, or the person's legal representative, when the CMEB has accepted a recommendation of a finding of no probable cause, and (c) developing systems for public access to information received about medical malpractice claims, awards and

[2] In FY 03, there were 52,308 civil cases added: 383 of which were medical malpractice.

settlements and reporting on the same to the Public Health and Insurance Committees by July 1, 2004.

The DPH will incur FY 05 costs of $613,340 to comply with **Sections 7-9 and 14.** This reflects the full-year salaries of: one Physician (at $142,000 annually), one Supervising Nurse Consultant (at $77,400 annually), two Health Program Associates (at $55,280 annually), two Nurse Consultants (at $66,640 annually), one Administrative Hearings Officer (at an annual salary of $70,000), one Office Assistant (at an annual salary of $34,870), and one half-time Systems Developer (at $31,230 annually). Also included are one-time equipment costs of $8,000 and other expenses of $5,000. In FY 06 this cost will decrease to $604,340 as equipment costs will not recur. DPH costs will be supplemented by fringe benefit[3] costs of $121,250 in FY 05 and $274,620 in FY 06. A potential minimal revenue gain would be expected should the enhanced investigation process lead to the collection of additional financial penalties from health care professionals. Since the bill is effective from passage, FY 04 costs of approximately $50,500 (DPH) and $10,100 (fringe benefits) would ensue given June 1, 2004 implementation.

Section 9 requires the Connecticut Medical Examining Board (CMEB) to adopt regulations by December 31, 2004, to establish guidelines for use in its disciplinary process. It also establishes a requirement that the CMEB refer all findings of no probable cause to a medical hearing panel within 60 days of receipt from the DPH. The CMEB and medical hearing panels are comprised of volunteers who are not compensated for their time. Therefore, no direct state cost will result from an increased workload of their members.

[3] The fringe benefit costs for state employees are budgeted centrally in the Miscellaneous Accounts administered by the Comptroller. The total fringe benefit reimbursement rate as a percentage of payroll is 45.82%, effective July 1, 2003. However, first year fringe benefit costs for new positions do not include pension costs - lowering the rate to 20.23% in FY 05. The state's pension contribution is based upon the prior year's certification by the actuary for the State Employees Retirement System.

Section 10 requires the DPH to include additional information related to medical malpractice investigations in its annual report to the General Assembly. The department will incur FY 05 costs of $92,940 to support the salary of one half-time Office Assistant (at an annual salary of $17,440) needed to enter data not presently collected and/or entered into the agency's database, one-time associated equipment costs of $3,000, and costs of one-time data processing services (approximately $72,500) needed to revise the agency's computer database and develop reporting tools. In FY 06 this cost will fall to $17,440, as the consultant services will no longer be required. DPH costs will be supplemented by fringe benefit costs of $3,530 in FY 05 and $7,990 in FY 06.

Section 11 requires each licensed hospital or outpatient surgical facility to establish protocols for screening patients prior to surgery. The development and implementation of these protocols will lead to additional costs for the John Dempsey Hospital at the University of Connecticut Health Center. However, given the required assistance of DPH in the development of these protocols as well as potential coordination with other hospitals in the state, these additional costs are expected to be minimal. No fiscal impact will result for the Department of Public Health.

To the extent that the measures in this bill lower medical malpractice and malpractice insurance costs, the John Dempsey Hospital at the University of Connecticut Health Center may realize future savings. The extent of these savings cannot be determined at this time.

Section 12 changes the rate of interest applied to offers of judgment made by plaintiffs after the effective date of the bill. Specifically, it pegs the interest rate applicable to offers of judgment at four percentage points above the weekly average five-year constant maturity yield of United States Treasury Securities. This would effectively reduce the rate of interest on offers of judgment from 12 per cent under current law to 7 per cent, although that difference would

diminish as US Treasury Securities yields and interest rates rise.

Section 13 requires insurance companies that offer property and casualty insurance in Connecticut and medical malpractice insurance in any state to offer medical malpractice insurance in Connecticut for specific health care providers and entities, as regulated by the Insurance Commissioner. This has no fiscal impact on the Department of Insurance.

Section 15 requires each physician, podiatrist, chiropractor and naturopathic physician to report the name of the insurance company providing his or her professional liability insurance, the policy number, his or her area of specialization and whether he or she is actively involved in patient care. It also allows DPH to compare this information to that contained in the National Practitioner Data Base. **Section 16** requires the DPH to report, by January 1, 2005, and annually thereafter, on the number of physicians by specialty who are actively providing patient care.

The DPH will incur FY 05 costs of $70,600 to support the salaries of one Office Assistant (at an annual salary of $34,870), and one half-time Systems Developer (at an annual salary of $31,230) needed to revise the agency's existing licensure database, enter information, follow-up with physicians who fail to supply the required data, and compile the annual report. Also included in this sum are one-time costs for equipment ($3,000) and reprinting the physician renewal card ($1,500). In FY 06 this cost will fall to $66,100 as one-time equipment and printing costs will not recur. DPH costs will be supplemented by fringe benefit costs of $6,320 in FY 05 and $14,310 in FY 06. It is anticipated that DPH will conduct few National Practitioner Data Bank checks, since each query costs $4.25 and no funding has been appropriated to the department for this purpose.

Section 17 requires medical malpractice insurance companies to offer a discount to any insured that will use an electronic health record system to maintain patient records and verify patient treatment. This has no fiscal impact on the Department of Insurance.

Section 18 requires the quasi-public, Connecticut Health and Educational Facilities Authority (CHEFA) to establish a program to finance low interest loans to hospitals to install or upgrade electronic health record systems for the establishment and maintenance of patient records and verification of patient treatment. It is anticipated that CHEFA will have sufficient reserves to finance the loan program.

Section 19 requires medical malpractice insurance companies to file a request for rate approval with the Insurance Commissioner 60 days prior to the effective date. This has no fiscal impact on the Department of Insurance.

Sections 20 & 21 require that captive insurers submit an application and a nonrefundable fee of $175 to the Insurance Commissioner in order to obtain a certificate of authority. Furthermore, the captive insurer must pay all expenses incurred as a result of filing the application. Currently, it is unknown how many captive insurers are in the state, as it is not a regulated industry. The bill also authorizes the commissioner, upon determination, to impose a civil penalty, with a maximum fine of $10,000. This will result in minimal revenue gain.

Section 22 permits any party to a medical malpractice civil action to request that the Chief Court Administrator designate the case as a complex litigation case. This conforms statute to current practice and, thus, there is no fiscal impact.[4]

Section 23 requires the court to grant any waiver of attorneys' contingency fees in medical malpractice cases. There is no related fiscal impact.

Section 24 requires the Insurance Commissioner to create and maintain an information database. The department already collects much of the information that the bill requires. This does not result in a fiscal impact.

OLR Bill Analysis
sSB 60

AN ACT CONCERNING MEDICAL MALPRACTICE

SUMMARY:
This bill makes numerous changes to the laws dealing with civil litigation; insurance regulation and oversight; and the regulation, oversight, and disciplining of doctors.

Civil Litigation Reform (Sections 1-6, 12, 22 and 23)

The bill:

1. authorizes professional societies or associations that represent health care providers, instead of only the Connecticut State Medical Society, to recommend names for the Medical Malpractice Screening Panel;
2. mandates the use of the Medical Malpractice Screening Panel, unless all parties agree to go directly to court and increases its membership of the hearing panel in malpractice cases from three to four by adding a judge trial referee to serve as chairperson;
3. gives immunity to anyone who provides testimony or information to a hearing panel, unless he acted with malice;
4. requires, as a condition of filing a medical malpractice lawsuit, that a signed opinion of a similar health care practitioner (a) be prepared to show the existence of a good faith belief that there has been negligence and (b) a copy be attached to the lawsuit complaint;
5. reduces the amount of interest that a defendant must pay under the offer of judgment law from a flat rate of 12% to 4% above the interest rate on a two-year Treasury bill and authorizes the defendants to get an extension of up to 120 days to respond to the offer;
6. allows attorneys for plaintiffs or defendants to ask that their case be put on the complex litigation docket; and
7. allows the attorney fee schedule for contingency fees to be waived

[4] In calendar year 2003, nine per cent of the 423 cases added to the complex litigation docket were medical malpractice cases: thirteen per cent of the 359 cases disposed of were medical malpractice cases.

only upon an application to and approval by a judge. The burden is on the claimant's attorney to show that deviation from the schedule is warranted due to the nature of the case.

Insurance Regulation and Oversight (§§ 13,17, 19, 20, 21, 24)

The bill:

1. requires insurance companies that offer property and casualty policies in Connecticut and medical malpractice policies in other states to offer medical malpractice insurance in Connecticut;
2. requires insurance companies to offer discounts to health care providers with electronic health records;
3. requires prior rate approval by the Insurance Department for all medical malpractice insurance rates;
4. requires captive insurers to get a certificate of authority from the Insurance Department and provide it with certain financial information and establishes a $175 fee for the issuance or renewal of a certificate of authority; and
5. beginning June 1, 2005, requires entities that insure people or entities against medical malpractice lawsuits to provide the insurance commissioner with a closed claim report on each malpractice claim that the insurer closes. The report must include details about the insured and insurer, the injury or loss, the claims process, and the amount paid. The bill requires the commissioner to compile and analyze the data and annually submit a report on this to the Insurance and Real Estate Committee and the public.

Regulation, Oversight, and Discipline of Medical Providers (§§ 7, 8, 9, 10, 11, 14, 15, 16, 18)

The bill:

1. requires anyone who pays a medical malpractice award or settlement to provide copies of the award to settlement and complaint and answer, if any, to the Insurance Department instead of just the Department of Public Health (DPH).
2. requires DPH to adopt guidelines to determine the basis for further investigation or disciplinary action;
3. requires DPH and the insurance commissioner to develop systems to collect, store, use, interpret, report, and provide public access to such information;

4. makes release of liability invalid until the attorney representing the paying party files an affidavit with the court that he has provided DPH and the insurance commissioner with the required information;
5. requires DPH to adopt regulations establishing guidelines for screening complaints, prohibiting investigation, and determining when an investigation should be broadened;
6. requires the Medical Malpractice Examining Board, with DPH's assistance, to adopt guidelines for its disciplinary process and requires DPH's commissioner to conduct a hearing on charges against a doctor if a hearing panel the board appoints has not done so within 60 days after the board reports charges to it;
7. requires that any finding of no probable cause by DPH after investigation be reviewed by a hearing panel the board appoints and authorizes the panel to ask DPH to provide more information or reconsider its findings;
8. requires that DPH's annual report to the governor and Public Health Committee include additional information such as the number of complaints filed against doctors, and the number of notices of malpractice lawsuits filed that were not investigated and the reasons why;
9. requires hospitals and outpatients surgical facilities to establish certain presurgery protocols;
10. requires DPH to notify those who file petitions with it against doctors when it makes a finding of no probable cause and indicate the reason for its finding;
11. requires doctors to annually provide certain information to DPH, including their malpractice insurer, policy number, area of specialization, and disciplinary actions and malpractice payments made in other jurisdictions;
12. requires DPH to report annually the number of doctors, by specialty, who are actively providing patient care; and
13. requires CHEFA to establish a loan program for hospitals to upgrade their health record system.

EFFECTIVE DATE: The bill takes effect upon passage, except the provisions requiring insurance companies to offer medical malpractice insurance, and discounts to providers with electronic health records, and requiring CHEFA to establish a loan program for hospitals to upgrade their health record system take effect July 1, 2004; the provisions requiring captive insurers to receive a certificate of authority and provide certain information to the commissioner take

effect October 1, 2004; and the provision regarding closed claims reporting takes effect January 1, 2005.

MEDICAL MALPRACTICE SCREENING PANEL—SELECTION OF MEMBERS (§ 1)

Under current law, members of the Medical Malpractice Screening Panel which is within the Insurance Department are selected from names supplied by the Connecticut State Medical Society (CSMS) and the Connecticut Bar Association (CBA). The bill requires that the professional societies or associations that represent health care providers in Connecticut also provide names for the panel.

It also makes technical and conforming changes.

MANDATORY PANEL SERVICE AND PANEL MAKE-UP (§ 2)

Under current law, the use of the malpractice screening panel is voluntary. Instead, the bill requires that, unless all parties agree to go directly to court, no lawsuit may be filed until the proposed complaint is filed with the insurance commissioner and a hearing panel has made and recorded a finding as to liability or dismissed the claim.

The bill requires the claimant to personally deliver or have delivered, or send, by registered or certified mail, return receipt requested, the proposed complaint to the commissioner. Within 10 days after receiving the complaint, she must send a copy of it by registered or certified mail, return receipt requested, to each health care provider named as a defendant at his last known place of residence or business. The filing of a complaint with the commissioner tolls the statute of limitations until 60 days after the date the claimant receives a copy of the hearing panel's finding or decision dismissing the claim.

The bill requires the commissioner to select a panel within 30 days after the complaint is filed. Under current law, the panel consists of two physicians and one attorney. Under the bill, the panel consists of two health care providers, one attorney, and a judge trial referee. The bill defines a "health care provider" as (1) a person licensed by Connecticut to provide health care or professional services or (2) an officer, employee, or agent of a corporation, facility, or institution licensed by this state to do so, acting in the course and scope of his employment.

Current law requires that at least one physician be of the same specialty as the physician accused of malpractice. The bill instead requires that one health care provider be from the same profession or specialty as the health care provider against whom the claim is filed and the other be from a hospital, outpatient, surgical facility, or outpatient clinic.

Under current law, the attorney acts as chairperson of the panel. Instead, the bill requires the insurance commissioner to notify the chief court administrator who, must, within 30 days, select a judge trial referee to be a member and chairperson of the panel.

The bill authorizes the chairperson, whenever he deems it necessary due to the nature of the claim or the parties, to select additional hearing panel members from the Medical Malpractice Screening Panel.

§ 3

This section makes technical changes.

IMMUNITY FOR WITNESSES (§ 4)

The bill immunizes anyone who provides testimony or information to a hearing panel on any matter submitted to it may, without a showing of malice, from damages resulting from such testimony or information.

§ 5

This section makes technical changes.

GOOD FAITH CERTIFICATE (§ 6)

Current law prohibits filing malpractice lawsuits unless the attorney or claimant made a reasonable inquiry as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the claimant's care or treatment. The complaint or initial pleading must contain a certificate of the attorney or claimant that such reasonable inquiry resulted in a good faith belief that grounds exist for a lawsuit against each named defendant.

Under current law, a good faith belief may be shown if the claimant or his attorney receives written opinion from a similar health care provider that there appears to be evidence of medical negligence. The bill instead requires that there be a written opinion to show the existence of good faith. It requires that the opinion include a detailed

basis for the formation of such opinion.

The bill requires the claimant or his attorney to retain the original written opinion and attach a copy of it to the complaint, with the similar health care provider's name and signature removed. Under existing law, unchanged by the bill, in addition to the written opinion, the court may consider other factors with regard to the existence of good faith.

Under existing law, unchanged by the bill, the court must impose upon the person who signed the certificate an appropriate sanction if it determines, after the completion of discovery, that the certificate was not made in good faith and that no valid issue was presented against a health care provider that fully cooperated in providing informal discovery. It may also impose the sanction on the claimant. The sanction may include an order to pay to the other party or parties the reasonable expenses incurred because of the filing of the pleading, motion, or other paper, including a reasonable attorney's fee. The court may also submit the matter to the appropriate authority for disciplinary review of the attorney if the claimant's attorney submitted the certificate.

NOTICE OF LAWSUITS TO DHS (§ 7)

The bill requires anyone filing a medical malpractice case against certain health care providers to mail a copy of the complaint to the Department of Public Health (DPH). The requirement applies to lawsuits filed against licensed physicians, chiropractors, naturopaths, dentists, and psychologists.

Existing law requires that anyone who pays damages in any medical malpractice case notify DPH of the terms of the award or settlement and provide a copy of the award or settlement and the underlying complaint and answer, if any. The bill requires that the person provide a copy of the award or settlement instead of notifying DPH of their terms. It appears to specify the portion attributable to economic damages and the portion of the award or settlement attributable to noneconomic damages. It also appears to require that if there are multiple defendants, it include the allocation for payment of the award between or among such defendants (see COMMENT).

The bill (1) requires that the person who pays damages also provide this information to the Insurance Department, (2) specifies that the

copies provided to the department may not identify the parties to the claim, and (3) requires that DPH send this information to the state board of examiners that oversees the health care provider who was a defendant in the lawsuit.

Under current law, DPH must review all medical malpractice awards and all settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. The bill requires that DPH also review all malpractice claims as well. It requires that, beginning July 1, 2004, DPH conduct its reviews in accordance with guidelines DPH adopts to determine the basis for such further investigation or disciplinary action.

The bill requires the DPH and insurance commissioners to develop systems within their respective agencies for collecting, storing, using, interpreting, reporting, and providing public access to the information they receive. It requires each commissioner to report the details of such systems within its agency to the Public Health and Insurance and Real Estate committees by July 1, 2004.

Release of Liability

Under current law and practice, people receiving a settlement in a malpractice claim sign a liability release to the person or entity paying the settlement. The bill makes such releases invalid until the attorney for the entity making payment on behalf of a party or, if no such entity exists, the attorney for the party, files with the court an affidavit stating that he has provided the information the bill and law require to DPH and the Insurance Department.

DPH INVESTIGATION OF COMPLAINTS AGAINST PHYSICIANS (§ 8)

By law, the DPH commissioner, with the Connecticut Medical Examing Board's advice and assistance, may establish regulations to carry out its oversight and regulatory duties.

The bill requires the commissioner, by July 1, 2004, to adopt regulations that establish (1) guidelines for screening complaints that physicians may be unable to practice medicine with reasonable skill and safety to determine which complaints will be investigated; (2) a prioritization system for conducting investigations to ensure prompt

action when it appears necessary; and (3) guidelines to determine when an investigation should be broadened beyond the initial complaint to include sampling patient records to identify patterns of care, reviewing office practices and procedures, reviewing performance and discharge data from hospitals and managed care organizations, and additional interviews of patients and peers.

DISCIPLINARY PROCEEDINGS AGAINST DOCTORS (§ 9)

The 15-member Connecticut Medical Examining Board (the board) is empowered to restrict, suspend, or revoke the license of a physician or limit his right to practice for certain misconduct.

The bill requires that by December 31, 2004, the board, with DPH's assistance, adopt regulations that establish guidelines for use in the disciplinary process. The guidelines must include, but need not be limited to (1) identification of each type of violation; (2) minimum and maximum penalties for each type of violation; (3) additional optional conditions that the board may impose for each violation; (4) identification of factors the board must consider in determining if the maximum or minimum penalty should apply; (5) conditions, such as mitigating factors or other facts, that may be considered in allowing deviations from the guidelines; and (6) a provision that when a deviation from the guidelines occurs, the reason for the deviation must be identified.

By law, the board must refer all statements of charges DPH files with it to a medical hearing panel within 60 days of receiving them. Also by law, the panel must conduct a hearing concerning contested cases. The panel must file a proposed final decision with the board within 120 days of the receipt of the issuance of the notice of hearing by the board. The board may, for good cause, vote to extend both of these deadlines.

The bill requires the DPH commissioner to conduct the hearing if the panel has not done so within 60 days of the date of referral of the statement of charges by the board. The hearing must be conducted in accordance with the regulations the commissioner adopts concerning contested cases. The bill requires the commissioner to file a proposed final decision with the board within 60 days after the hearing. The board may extend the filing deadlines in a recorded vote.

The bill requires the board to refer all findings of no probable cause

that DPH files with it to a medical hearing panel within 60 days of receiving the charges. The board may extend this deadline for good cause by a duly recorded vote. The panel must review the petition and the entire record of the investigation and may ask DPH to provide more information or reconsider its finding. If the panel takes no action within 90 days after DPH submits the finding to the board it is considered final.

DPH GUIDELINES FOR REVIEW OF MALPRACTICE AWARDS AND SETTLEMENTS (§ 10)

By law, DPH must review all medical malpractice awards and settlements to determine whether further investigation or disciplinary action against the providers involved is warranted. It must also file with the governor and the Public Health Committee an annual report of its disciplinary activities, which must include certain information. The bill requires that the report specify the number of petitions not investigated and the reasons why, the outcome of the hearings held on such petitions, and the timeliness of action taken on petitions considered to be a priority.

PRE-SURGICAL PROTOCOLS (§ 11)

The bill requires each licensed hospital or outpatient surgical facility to establish protocols for screening patients before surgery. These protocols must require that before surgery, members of the surgical team, including at least one principal surgeon, but not exceeding five such members in total, together (1) identify the patient and, where the patient is able to do so, have the patient identify himself and (2) identify the procedure to be performed. They must also require that no patient may be anesthetized and no surgery may be performed unless this identification process has been confirmed by all team members. But, the bill allows the protocols to provide for alternative identification procedures where the patient is unconscious or under emergency circumstances. The bill requires each licensed hospital or outpatient surgical facility annually to submit to DPH a copy of the protocols and a report on their implementation.

The bill directs DPH to assist each hospital or outpatient surgical facility to develop and implement these screening protocols.

OFFER OF JUDGMENT (§ 12)

Under current law, the plaintiff in a contract case or a case seeking money damages, may up to 30 days before trial, file with the court clerk a written "offer of judgment" offering to settle the claim for a specific amount. After trial, the court must examine the record to determine whether the plaintiff made an offer of judgment, which the defendant failed to accept. If it determines that the plaintiff recovered an amount equal to or greater than the sum certain stated in the plaintiff's offer of judgment, the court must add 12% annual interest.

By law, a defendant has 60 days to file with the clerk an acceptance of the offer. The bill allows the court to grant the defendant one or more extensions up to 120 additional days to file an acceptance.

The bill changes the interest rate the court may award with respect to an offer of judgment filed on or after the bill's effective date. Specifically, it authorizes the court to add interest at an annual rate of 4% above the weekly average five-year constant maturity yield of United States Treasury securities, as published by the Board of Governors of the Federal Reserve System, for the calendar week preceding the beginning of each year for which interest is owed, with respect to an offer of judgment filed on or after the effective date of this section.

REQUIRING COMPANIES TO OFFER MALPRACTICE INSURANCE (§ 13)

The bill requires insurance companies that issue property and casualty policies in Connecticut and issue medical malpractice policies in any state, district, or territory of the United States to offer medical malpractice insurance in Connecticut for (1) physicians and surgeons, (2) hospitals, (3) dentists, (4) chiropractors, (5) licensed naturopaths, (6) podiatrists, (7) advanced practice registered nurses, and (8) other categories as the insurance commissioner adopts by regulation.

DPH INVESTIGATION OF PETITIONS (§ 14)

The law requires DPH to investigate each petition filed with it to determine if probable cause exists to issue a statement of charges and to institute proceedings against the physician.

Under current law, the investigation must be concluded within 18 months from the date the petition was filed. The investigation is

confidential and no one may disclose his knowledge of it to a third party unless the physician asks that the investigation be opened. If DPH determines that probable cause exists to issue a statement of charges, the entire record is public unless it determines the physician is an appropriate candidate for participation in a rehabilitation program and the physician agrees to participate in accordance with terms agreed upon by DPH and the physician. If after the filing of a petition and during the 18-month period, DPH makes a finding of no probable cause, the petition and the entire record of the investigation must remain confidential unless the physician asks that such petition and record be open. The bill specifies that the investigation remain confidential only if the medical panel the board appointed allows the finding of no probable cause to stand.

The bill requires DPH to notify the person who filed a petition or his legal representative when it makes a finding of no probable cause. It must include the reason for such finding.

DPH DATA REGARDING PRACTITIONERS (§ 15)

By law, each person holding a license to practice medicine, surgery, podiatry, chiropractic or naturopathy must annually register with DPH and provide his name, residence, and business address, and other information DPH requests. The bill also requires him to provide the name of the insurance company providing his malpractice insurance and the policy number, his area of specialization, whether he is actively involved in patient care, and any disciplinary action against him or malpractice payments made on his behalf in any other state or jurisdiction. The bill authorizes DPH to compare the information submitted to information contained in the National Practitioner Data Base.

NUMBER OF PHYSICIANS (§ 16)

The bill requires DPH by January 1, 2005, and annually thereafter, to report to the Senate and House clerks, the state librarian, and the Office of Legislative Research the number of physicians by specialty who are actively providing patient care in Connecticut.

REQUIRED DISCOUNTS—ELECTRONIC HEALTH RECORDS (§ 17)

The bill requires medical malpractice insurance companies to offer a

premium discount on the policy to any insured that submits to the insurer proof that it will use an electronic health record system during the premium period to establish and maintain patient records and verify patient treatment. The discount must be at least 20% of the premium for a period of one year from the effective date of the policy or renewal.

LOANS FOR ELECTRONIC HEALTH RECORD SYSTEMS (§ 18)

The bill requires the Connecticut Health and Educational Facilities Authority to establish a program, within available appropriations, to finance low interest loans to hospitals to install or upgrade electronic health record systems for establishing and maintaining patient records and verifying of patient treatment. The program will be known as the Connecticut Electronic Health Records Program. The bill authorizes loans to establish and upgrade electronic health record systems for use by hospitals in order to promote patient safety and eliminate errors.

PRIOR RATE APPROVAL (§ 19)

The bill subjects malpractice insurance rates for physicians and surgeons, hospitals, or advanced practice registered nurses to prior rate approval by the insurance commissioner. On and after the bill's effective date, each insurer or rating organization seeking to change its rates for such insurance must (1) file a request for such change with the Insurance Department and (2) provide written notice to its insureds with respect to any request for a rate increase.

They must file the request and send the notice at least 60 days before the change's effective date. The notice must indicate that a public hearing will be held. The Insurance Department must review the request and, hold a public hearing on the rate increase before approving or denying it. The bill gives the commissioner 45 days to approve or deny the request. Her findings may be appealed to Superior Court.

CAPTIVE INSURERS (§§ 20 AND 21)

Beginning October 1, 2004, the bill prohibits captive insurers from insuring a health care provider or entity in this state against liability for medical malpractice unless it has obtained a certificate of authority from the insurance commissioner. It does not require a certificate of

authority for captive insurers duly licensed in Connecticut to offer such insurance. The bill establishes a $175 fee for each certificate issued.

A "captive insurer" is an insurance company owned by another organization whose exclusive purpose is to insure risks of the parent organization and affiliated companies. In the case of groups and associations, it is an insurance organization owned by the insureds whose exclusive purpose is to insure risks of member organizations and group members and their affiliates.

Application to Insurance Commissioner

The bill requires any captive insurer seeking to obtain a certificate of authority to apply to the commissioner, on such form as she requires, specifying the line or lines of business, which it is seeking authorization to write. The captive insurer must file with the commissioner (1) a certified copy of its charter or articles of association, (2) evidence satisfactory to the commissioner that it has complied with the laws of the jurisdiction under which it is organized, (3) a statement of its financial condition together with whatever evidence of its correctness the commissioner requires, and (4) evidence of good management in such form as the commissioner requires.

The bill requires the captive insurer to submit evidence of its ability to provide continuous and timely claims settlement. It authorizes the commissioner to issue to such insurer a certificate of authority permitting it to do business in Connecticut if she finds that information furnished is satisfactory, and the insurer complied with all other requirements of law. The certificate expires on the first day of May succeeding the date of its issuance, but may be renewed without any formalities except as the commissioner requires.

The bill requires the commissioner to adopt regulations specifying the information and evidence that a captive insurer seeking to obtain or renew a certificate of authority must submit and the requirements with which it must comply.

Cause for Revocation

Under the bill, the failure of a captive insurer to exercise its authority to write a particular line or lines of business in Connecticut for two consecutive calendar years may constitute sufficient cause for revoking

its authority to write those lines of business.

The bill authorizes the commissioner, for cause, after notice and a hearing, to suspend, revoke, or reissue a certificate of authority. She may also impose a fine of up to $10,000. The bill authorizes the commissioner or her designee to hold the hearings. The bill mandates that whenever any one other than the commissioner acts as the hearing officer, he must submit to the commissioner a memorandum of findings and recommendations upon which she may base a decision. The commissioner may, if the commissioner deems it in the public interest, publish in one or more state newspapers a statement that she has suspended or revoked the certificate of authority of any captive insurer to do business in Connecticut.

The bill requires the applicant to pay all expenses the commissioner incurs in connection with a captive insurer.

Any captive insurer aggrieved by the commissioner's action in revoking, suspending, or refusing to reissue a certificate of authority, or in imposing a fine may appeal to Superior Court. The appeal must be filed in the New Britain Judicial District.

COMPLEX LITIGATION DOCKET (§ 22)

The bill authorizes any party to a medical malpractice lawsuit to file an application with the Superior Court asking that the case be designated as a complex litigation case and that the chief court administrator or any judge he designates transfer it to the complex litigation docket in a judicial district and court location determined by the chief court administrator or such designee.

CONTINGENCY FEE (§ 23)

Current law establishes a sliding scale on contingency fees attorneys may charge clients. It establishes an upper limit on contingency fees attorneys may collect from their clients based on the amount of the settlement or judgment. It allows 33 1/3% of the first $ 300,000, 25% of the next $300,000, 20% of the next $ 300,000, 15% of the next $300,000 and 10% of amounts exceeding $1,250,000. This sliding scale applies to any lawsuit to recover damages resulting from personal injury, wrongful death, or property damage involving contingency fees, not just to medical malpractice cases. A Superior Court judge interpreted

this law to alllow clients to waive its protections and agree to pay a higher contingency fee (See BACKGROUND).

The bill makes fee waivers invalid in a medical malpractice case unless the claimant's attorney files an application with the court for approval of such arrangement and the court, after a hearing, grants such application. The bill requires the claimant's attorney to attach to the application a copy of the fee arrangement and the proposed unsigned writ, summons and complaint in the case. The court must grant the application if it finds that the case is sufficiently complex, unique, or different from other medical malpractice cases so as to warrant a deviation from the percentage limitations. At the hearing, the claimant's attorney has the burden of showing that the deviation is warranted.

If the court does not grant the application, it must advise the claimant of his right to seek representation by another attorney willing to abide by the percentage limitations set forth in law. The filing of such application tolls the applicable statute of limitations for a period of 90 days.

Method by Which Fee is Calculated

For all contingency fee arrangements, not just those involving medical malpractice cases, the bill requires that the percentages that go to the client and to the attorney be calculated after deductions for any disbursements or costs the attorney incurred, other than ordinary office overhead and expenses.

MEDICAL MALPRACTICE DATA BASE (§ 24)

Current law authorizes the insurance commissioner to require all insurance companies writing medical malpractice insurance in Connecticut to submit, in such manner and at such times as she specifies, whatever information she deems necessary to establish a database on medical malpractice. The database may include information on all incidents of medical malpractice, all settlements, all awards, other information relative to procedures and specialties involved, and any other information relating to risk management.

The bill eliminates this authority and instead, beginning January 1, 2005, requires each insurer to provide to the commissioner a closed

claim report, on whatever form the commissioner requires. A "closed claim" is a claim that has been settled, or otherwise disposed of, where the insurer has made all indemnity and expense payments on the claim. The duty to report applies to a captive insurer or a self-insured person.

The bill requires the insurer to submit the report within 10 days after the last day of the calendar quarter in which a claim for recovery under a medical liability policy is closed. The report must include information only about claims settled under the laws of this state. It must include details about the insured and insurer, the injury or loss, the claims process, and the amount paid on the claim.

Details About the Insured and Insurer

The bill requires details about the insured and insurer to include the (1) insurer's name, (2) professional liability insurance policy limits and whether the policy was an occurrence policy or was issued on a claims-made basis; (3) name, address, health care provider professional license number and specialty coverage of the insured; and (4) insured's policy number and a unique claim number.

Details About the Injury or Loss

The bill specifies that details about the injury or loss, include the (1) date of the injury or loss that was the basis of the claim; (2) date the injury or loss was reported to the insurer; (3) name of the institution or location at which the injury or loss occurred; (4) type of injury or loss, including a severity of injury rating that corresponds with the injury scale that the commissioner must establish based on the severity of injury scale developed by the National Association of insurance commissioners; and (5) name, age and gender of any injured person covered by the claim. Any individually identifiable information must be confidential.

Details About the Claims Process

The bill specifies that details about the claims process, include: (1) whether a lawsuit was filed, and if so, in which court; (2) the outcome of such lawsuit; (3) the number of other defendants, if any; (4) the stage in the process when the claim was closed; (5) the trial dates; (6) the date of the judgment or settlement, if any; (7) whether an appeal was

filed, and if so, the date filed; (8) the resolution of the appeal and the date such appeal was decided; (9) the date the claim was closed; (10) the initial indemnity and expense reserve for the claim; and (11) the final indemnity and expense reserve for the claim.

Details About the Amount Paid on the Claim

The bill specifies that details about the amount paid on the claim include

1. the total amount of the initial judgment rendered by a jury or awarded by the court;
2. the total amount of the settlement if there was no judgment rendered or awarded;
3. the total amount of the settlement if the claim was settled after judgment was rendered or awarded;
4. the amount of economic damages, or the insurer's estimate of the amount in the event of a settlement;
5. the amount of noneconomic damages, or the insurer's estimate of the amount in the event of a settlement;
6. the amount of any interest awarded due to failure to accept an offer of judgment;
7. the amount of any remittitur or additur;
8. the amount of final judgment after remittitur or additur;
9. the amount paid by the insurer;
10. the amount paid by the defendant due to a deductible or a judgment or settlement in excess of policy limits;
11. the amount paid by other insurers;
12. the amount paid by other defendants;
13. whether a structured settlement was used;
14. the expense assigned to and recorded with the claim, including, but not limited to, defense and investigation costs, but not including the actual claim payment; and
15. any other information the commissioner determines to be necessary to regulate the professional liability insurance industry with respect to medical professionals and entities, ensure the industry's solvency, and ensure that such liability insurance is available and affordable.

The bill requires the commissioner to establish an electronic database composed of closed claim reports.

Annual Summary of Data

The bill requires the commissioner to compile the data included in individual closed claim reports into an aggregated, summary format and prepare a written annual report of the summary data. The report must provide an analysis of closed claim information, including a minimum of five years of comparative data, when available, trends in frequency and severity of claims, itemization of damages, timeliness of the claims process, and any other descriptive or analytical information that would assist in interpreting the trends in closed claims.

The bill requires the annual report to include a summary of rate filings for professional liability insurance for medical professionals and entities that the department approved for the prior calendar year. The summary must include an analysis of the trend of direct losses, incurred losses, earned premiums and investment income as compared to prior years. The report must also include base premiums charged by medical malpractice insurers for each specialty and the number of providers insured by specialty for each insurer.

The bill requires that by March 15, 2006, and annually thereafter, the commissioner must submit the annual report to the Insurance and Real Estate Committee. The commissioner must also (1) make the report available to the public, (2) post the report on its Internet site, and (3) provide public access to the contents of the electronic database after establishing that the names and other individually identifiable information about claimants and practitioners have been removed.

The bill requires the insurance commissioner provide the DPH commissioner with electronic access to all the closed case information she receives.

BACKGROUND

Attorney's Fees

Table 1 shows how the statutory formula under current law works for each of four hypothetical awards. In addition to showing the actual amount of fees the statute allows the attorney to collect, the table also shows the resulting percentage of the total award the attorney's fees constitute, the amount the client would receive, and the resulting percentage the client receives.

Table 1: Attorney's Fees for Various Damage Awards

Damage Award or Settlement	*Contingency Fee the Law Allows*	*Percentage of Total Award to Attorney*	*Amount Client Receives*	*Percentage of Total Award to Client*
$100,000	$33,333	33.33%	$66,667	66.67%
$500,000	$150,000	30%	$350,000	70%
$1,000,000	$250,000	25%	$750,000	75%
$5,000,000	$660,000	13.2%	$4,540,000	86.8%
$10,000,000	$1,160,000	11.6%	$8,8840,000	88.4%

Waiver of Fee Schedule

Current law does not explicitly indicate whether a client can waive the contingency fee limits that the statute imposes. One Superior Court case addressed this issue. Judge Vertefeuille held that tort victims could waive their right to the protections afforded by the contingency fee law. She also decided the plaintiff's waiver was valid, and the fee arrangement the plaintiff entered into with her attorney was reasonable (*In re Estate of Salerno,* 42 Conn. Supp. 526 (1993)).

Judge Vertefeuille resolved the case on nonconstitutional grounds. She first noted that rights granted by statute could be waived unless the statute is meant to protect the general rights of the public rather than private rights. She cited instances where statutes relating to litigation have been construed as conferring a private right that can be waived (e. g., statute of limitations for tort actions, right to trial by jury, defense of statute of fraud).

She concluded that the fee cap statute clearly confers a private right and does not protect the general rights of the public. She also cited the legislative history where proponents of the law indicated that it could be waived.

Related Bills

sSB 61, reported favorably by the Program Review and Investigations Committee on March 3, establishes a fund to reimburse a portion of a malpractice claim, settlement, or judgment, which represents the deductible portion applicable to a provider's coverage. It authorizes

the insurance commissioner to approve policies that contain deductibles up to $50,0000 for an individual and $100,000 for a hospital.

The bill establishes another fund that pays a portion of a malpractice award or settlement that exceeds certain amounts. The maximum amount the fund may pay per claim is $500,000.

SB 141, reported favorably by the Program Review and Investigations Committee on March 3, 2004, makes numerous changes to tort law, insurance regulation, and disciplining of health care providers. Tort reform provisions deal with such areas as offer of judgments, mediation, attorney's fees, elimination of the screening panel, and establishing a task force to study alternatives to a tort system. Insurance provisions include prior rate approval, data gathering, and captive insurers.

Other provisions deal with investigatory complaints against doctors, the complaint investigation process and standards, data gathering, mandatory continuing education for doctors, and a task force to examine the feasibility of developing a doctor relicensing exam.

sSB 394, reported favorably by the Insurance and Real Estate Committee on March 9, makes numerous changes to tort law; insurance regulation; and the oversight, regulation, and discipline of doctors. It is very similar to this bill except it contains a provision for a fund. The insurance provisions relate to prior rate approval, captive insurers, data collection, and the requirement of certain companies to offer malpractice insurance. It establishes surgery protocols, electronic medical records, and investigation of doctors.

COMMENT

Notice of Lawsuit-Mandatory Reporting

The bill defines "terms of the award or settlement" but it eliminates this phrase from the law being amended. Thus, it is not clear whether the definition, which deals with reporting economic and noneconomic damages, and multiple defendants applies.

COMMITTEE ACTION

Program Review and Investigations Committee

Joint Favorable Substitute
Yea 11 Nay 0